ADVERSE HEALTH EVENTS IN MINNESOTA

SEVENTH ANNUAL PUBLIC REPORT

JANUARY 2011

MINNESOTA MDH DEPARTMENT OF HEALTH

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This report can be found on the internet at:
www.health.state.mn.us/patientsafety

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EXECUTIVE SUMMARY

Adverse Health Events in Minnesota

Annual Report, January 2011

In 2003, Minnesota became the first state in the nation to pass a law requiring all hospitals, and later ambulatory surgical centers, to report whenever a serious adverse health event occurs and to conduct a thorough analysis of the reasons for the event. Seven years later, Minnesota's system continues to be an important tool for uncovering the system breakdowns that lead to adverse health events and sharing those learnings with facilities across the state. The reporting law has served as a catalyst for a number of statewide initiatives that bring hospitals and surgical centers together to tackle the most prevalent adverse events through a focus on implementing bundles of best practices for process and organizational change.

During the current reporting year, a total of 305 adverse health events were discovered and reported by Minnesota facilities, essentially unchanged from the previous year. The overall profile of reported events was similar to previous years, with falls, pressure ulcers, and retained foreign objects comprising the majority of events. Other results include:

- Ten deaths and 97 serious injuries resulted from the reported events.
- Last year's 20 percent reduction in falls associated with serious injury or death was largely maintained. In the current reporting year a total of 80 falls were reported, up from 76 in the previous year but down from a high of 95 two years ago.
- The number of serious bedsores remained roughly constant, decreasing from 122 to 118.
- The number of events related to surgery/invasive procedures remained unchanged at 83.

Prior to the inception of public reporting laws such as Minnesota's, serious adverse health events or errors were not tracked, and effective strategies for their prevention were often not shared beyond the individual facility in which the event occurred. As a result, safety leaders often were not aware of similar challenges faced by other facilities, and had to develop their own responses without knowledge about what had worked elsewhere. Minnesota's reporting system has a strong focus on accountability – making sure that all events are discovered and reported – but an even stronger focus on learning from each event so that additional harm can be prevented. Key learnings gleaned from 2010 events include:

- In response to the finding that more than 25 percent of reported pressure ulcers are associated with the use of a device such as a cervical collar, tube, or splint, a Minnesota Hospital Association (MHA) pressure ulcer advisory committee developed recommendations for prevention of pressure ulcers when cervical collars and respiratory devices are in use.
- As a result of data showing that the surgical site mark was not located and verbally confirmed as part of the time out process in more than a third of wrong site surgery cases, MDH and MHA issued a safety alert reminding facilities of the importance of this step in the verification process and providing guidance on how to properly implement it.
- Based on the finding that a number of falls involved patients who had previously reliably called for assistance with toileting, a falls advisory group is exploring actions to respond to changes in patient behavior around asking for assistance. Examples include providing additional education to patients when they are feeling better to remind them of the importance of calling for help, or earlier assessment and associated interventions for increased confusion.

Additional 2010 activities:

- A fifth statewide Call to Action kicked off at the end of 2009. The Safe Account campaign, sponsored by MHA, focuses on prevention of retained foreign objects in the operating room.
- In February 2010, reporting facilities were surveyed to assess their knowledge of reporting requirements. Facilities were provided with brief case studies, and asked to determine whether each case was reportable. The results and correct answers were discussed with facilities statewide, with several facilities also using the survey as a training tool for staff.
- In April, Stratis Health and MDH released the "Minnesota Adverse Health Events Measurement Guide," to assist facilities in effectively monitoring the

success of their corrective actions. Three companion training sessions were held across the state in August.

Despite these activities and the strong commitment of front line staff, patient safety leaders, and stakeholders around the state, preventable adverse health events continue to occur at a relatively constant rate in Minnesota and nationally. This is a time of a great deal of change in the health care system. Many facilities face increasing financial, regulatory or reporting pressures, and are heavily involved in transitioning to electronic medical records systems, even as they try to identify how state and national health reform efforts will change their day to day practices. These competing priorities can often lead to a loss of focus on patient safety, and insufficient resources allocated to system changes that might prevent harm.

In the coming year, MDH and its partners will continue to focus on identifying and disseminating information about risks and successful strategies for preventing these and other serious events, and to promote a statewide culture of safety. But healthcare leaders, in particular CEOs, boards of directors/trustees, and physician leaders, need to take all possible steps to ensure that prevention of patient harm is their highest priority, that front-line staff have the resources and support they need to provide safe care, and that all providers are fully engaged in activities to strengthen the system of care.

Hospital and surgical center CEOs and senior executives should:

- Start every meeting with a story about a patient's experience of preventable harm;
- Regularly observe clinical best practices (such as a pre-surgical time-out) in action;
- Establish formal, written 'hard stop' policies for critical practices;
- Meet with skin integrity, falls prevention, surgical safety and other teams to learn about challenges and barriers to progress;
- Participate in leadership walk-arounds; and
- Share best practice expectations and performance with the board of directors and with all staff, including licensed independent practitioners.

Boards of directors should:

- Start every meeting with a story about a patient's experience of preventable harm;
- Review safety data that includes actual numbers of patients harmed, not just rates and benchmarks;
- Publicize safety goals and performance; and
- Be required to attend periodic trainings on patient safety issues.

Without this type of strong, consistent action by health care leaders, progress in eliminating preventable harm to Minnesota patients is likely to plateau.

For more information about the adverse health events reporting system, visit **www.health.state.mn.us/patientsafety**.

HOW TO USE THIS REPORT

This report is one of many sources of information now available on health care quality and patient safety in Minnesota. It is designed to help patients identify safety issues to discuss with their care providers, and to give policymakers an overview of patient safety activities and issues in the state. But it is only one piece of the larger picture of patient safety and quality. Other good sources of information on health care quality and safety are listed at right.

For consumers, the best way to play a role in improving safety is by using reports like these to identify situations of concern and to learn why they happen, and to learn about what safe, high-quality health care should look like. Armed with that information, patients and family members can ask providers what is being done in their facility to prevent these types of events from occurring. The information in this report should be a basis for further learning, rather than just a way to compare facilities based on incidence rates.

Patient awareness is a very important tool to improve safety, but it is important to keep these numbers in perspective. The events listed in this report represent a very small fraction of all of the procedures and admissions at Minnesota hospitals and ambulatory surgical centers, and not all are preventable.

Reports might be higher or lower at a specific facility for a variety of reasons. A higher number of reported events does not necessarily mean that a facility is less safe, and a lower number does not necessarily mean the facility is safer. In some cases, the number of events may be higher at facilities that are especially vigilant about identifying and reporting errors. The reporting system itself may also have an effect, by fostering a culture in which staff feels more comfortable reporting potentially unsafe situations without fear of reprisal. It is important to note that in these cases, higher numbers may represent a positive trend towards greater attention to adverse events and their causes, rather than the opposite. What is important is that all events are an opportunity for learning and system improvement.

SOURCES OF QUALITY AND PATIENT SAFETY INFORMATION

Minnesota Department of Health
www.health.state.mn.us/patientsafety
Consumer guide to adverse events, database of adverse events by facility, fact sheets about different types of events, FAQs, and links to other sources of information.

http://www.health.state.mn.us/healthreform/measurement/report/index.html
2010 Minnesota Health Care Quality Report, comparing quality at hospitals and clinics on a set of measures including diabetes, high blood pressure, asthma, and cancer.

Minnesota Alliance for Patient Safety
www.mnpatientsafety.org
MAPS is a broad-based collaborative that works together to improve patient safety in MN. Projects include informed consent, health literacy, medication reconciliation, and Just Culture.

Minnesota Community Measurement
www.mnhealthcare.org
Comparative information about provider groups and clinics including best practices for diabetes, asthma, and other conditions, as well as who does the best job providing that care.

Stratis Health
www.stratishealth.org
A nonprofit organization that leads collaboration and innovation in health care quality and safety. Resources include tools to support clinical and organizational improvement, as well as training and education programs for professionals across the continuum of care.

Minnesota Hospital Quality Report
www.mnhospitalquality.org
Database of hospital performance on best practice indicators for heart attack, heart failure, pneumonia, surgical care and how patients experience care in the hospital.

The Leapfrog Group
www.leapfroggroup.org
Hospital safety and quality ratings based on multiple factors.

HIGHLIGHTS OF 2010 ACTIVITIES

Under the Minnesota Adverse Health Care Events Reporting Law, the Commissioner of Health is directed to review all reported events, root cause analyses, and corrective action plans, and provide direction to reporting facilities to ensure that the actions they take will be effective in preventing future harm. In performing these functions, MDH works closely with several key stakeholder organizations, including the Minnesota Hospital Association (MHA) and Stratis Health. Highlights of the past year's activities are listed below.

Education

- In March 2010, MDH sponsored two training sessions on the use of the Causal Tree and Fault Tree methodologies to analyze the causes of events.
- In April, Stratis Health and MDH released the "Minnesota Adverse Health Events Measurement Guide," to assist facilities in effectively monitoring the success of their corrective actions. Three companion training sessions were held across the state in August, with participation from 70 hospitals and surgical centers.
- Representatives from fifteen facilities participated in a Root Cause Analysis training session in June 2010. This training is an important way of supporting facilities as they work to conduct robust root cause analyses.
- MDH and MHA issued three safety alerts in 2010, reminding facilities of the importance of visualization and verbalization of the surgical site mark during the time-out process, confirming the need for site marking and a time-out for pre-operative anesthesia procedures, and providing guidance to senior leadership related to their role in ensuring that the Minnesota Safe Site process is followed for every procedure.
- In 2010, MDH began holding periodic statewide conference calls for reporting facilities, to update them on changes to the reporting system, new projects, and upcoming training opportunities.

Strengthening the reporting system

- MDH began working with the Minnesota Department of Human Services to assess the validity of Medicaid claims data as a source of information for nonpayment for certain adverse health events.
- In February 2010, MDH surveyed all reporting facilities to assess their knowledge of the reporting law's requirements. Facilities were provided with case studies, and asked to determine whether each case was reportable under the law. The results and correct answers were discussed with facilities statewide, with several facilities also using the survey as an internal training tool for staff.

Topic-specific safety activities

MHA continued to convene expert groups to examine trends and develop evidence-based strategies for prevention of falls, pressure ulcers, retained foreign objects in labor and delivery, and surgical events, as well as kicking off a new statewide campaign to prevent retained foreign objects in surgery. The pressure ulcer advisory group developed recommendations for prevention of pressure ulcers with the use of cervical collars and respiratory devices, which have been disseminated statewide.

A number of statewide and regional campaigns and individual facility efforts to prevent wrong site surgery, retained foreign objects, falls, and pressure ulcers were implemented or continued during 2010. Those efforts are described in the following sections.

2010 ACTIVITIES AND CHALLENGES: FACILITY PERSPECTIVES

In November 2010, MDH conducted a survey of all reporting facilities to learn more about their successes and challenges over the previous year and to allow facilities another avenue to provide input into the priorities and direction of the reporting system. A total of 168 facilities were surveyed using an online survey tool, with 87 responses received (52 percent).

Respondents were asked to rate the usefulness of a number of tools, training sessions, and resources developed by MDH, MHA and Stratis Health during the 2009-2010 reporting period. Their responses indicate that most facilities made use of a range of resources during the previous year, and rated the majority of the tools and training opportunities to be very or somewhat useful (Figure 1). The most highly-rated activities/resources were MDH/MHA safety alerts, the "Measurement Guide for Adverse Health Events," the five MHA Calls to Action, and the spring 2010 Case Study survey that measured facilities' awareness of reporting requirements through the use of vignettes.

Facilities were also asked to describe, in general terms, their biggest successes and challenges from the past year. A number of respondents described strong awareness of and engagement in patient safety initiatives by frontline staff and a greater understanding of what needs to be reported, as well as a greater willingness by staff to step up into leadership roles around safety initiatives and serve as 'champions.' Many respondents also described successful efforts related to preventing particular types of adverse events, most commonly wrong site surgery/ invasive procedures, falls and pressure ulcers.

But respondents also described an environment in which they face a number of challenges, including:

- Staff turnover and staff reductions leading to 'starting from scratch' with initiatives, a constant need to train new staff, and lack of sufficient staff to fully implement certain types of changes or campaigns.
- Keeping patient safety as a priority during a time of budget cuts, mergers/ownership changes, and competing demands for time.

FIGURE 1: FACILITY PERSPECTIVES

RESOURCES	VERY USEFUL	SOMEWHAT USEFUL	NEUTRAL	NOT VERY USEFUL
Call to Action participation	50.0%	36.5%	13.5%	0.0%
Call to Action listservs	32.4%	39.7%	26.5%	1.5%
Call to Action tools/templates	50.7%	42.5%	6.8%	0.0%
Case study survey	54.7%	28.1%	17.2%	0.0%
Causal tree training	44.4%	25.0%	30.6%	0.0%
MDH statewide AHE conference calls	44.9%	42.0%	13.0%	0.0%
MDH/MHA safety alerts	73.8%	20.0%	5.0%	1.3%
Measurement guide for adverse events	58.8%	36.3%	3.8%	1.3%
Measurement training	34.6%	44.2%	21.2%	0.0%
MHA 'Good Catch' awards program	9.9%	33.8%	43.7%	12.7%
MHA data sharing database	24.6%	47.7%	24.6%	3.1%
MHA/Stratis regional meetings	49.1%	29.1%	18.2%	3.6%
Participation in MHA advisory committees	47.1%	11.8%	38.2%	2.9%
RCA 101 training	45.9%	32.4%	18.9%	2.7%
Written comments from Stratis during review process	23.6%	43.6%	27.3%	5.5%
Phone/other consultation from Stratis during review process	42.6%	36.2%	17.0%	4.3%

** Responses are limited to facilities that indicated they had used/seen the resource.*

- Balancing resource and training needs related to the implementation of electronic medical records with other patient safety needs.
- Pushback or lack of engagement/compliance from physicians or other providers who may not understand or support the rationale for specific measures, such as time-outs in procedural areas.
- Difficulty keeping up with measurement/follow up when doing root cause analysis for 'good catch' or 'near miss' events in addition to reportable adverse events and other newly required measurement/reporting.

Respondents were also asked about resources that would be helpful to them in the coming year. Their responses indicated that facilities would be interested in additional resources, tools, or training related to:

- A 'beginner's toolkit' with information about what is reportable, how to report events, who to contact with questions, and how the reporting system is organized.
- How to deal with a lack of teamwork/shared agenda between hospital staff and physicians, and engage physicians more fully in safety initiatives.
- Best practices that organizations should use after an incident to manage communication between the involved parties.
- Toolkits and templates for common events, and opportunities to attend training via webinar.
- Resources related to particular categories of adverse health events, such as prevention of injuries when patients fall, prevention of medication errors, training on assessing pressure ulcers and documenting the stage, etc.

Responses from reporting facilities indicate that they appreciate the resources and training opportunities that are available from MDH, MHA and Stratis Health, but that they also face ongoing challenges to progress. Many of these issues are not related to front-line staff having the 'will' to move forward, but rather to conflicting demands on their time, challenges in engaging physicians, and difficulty accessing necessary resources.

MDH and its partners will move forward in 2011 with developing additional resources to meet these identified needs. But these responses highlight the need for leaders to send a strong message, through actions and not just words, that patient safety is paramount, to ensure that sufficient staff and resources are available, and to consider the impact of new technologies such as electronic health records on safety, workflow, and staff time.

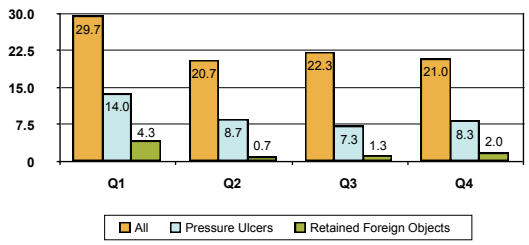
OVERVIEW OF REPORTED EVENTS & FINDINGS

In over seven years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on roughly 1,400 events. This annual report provides an overview of what the most recent year of data can teach us about the risk points for adverse health events and the best approaches for preventing them, with a particular focus on the most common types of events: falls, pressure ulcers, wrong-site surgeries or invasive procedures, and retained foreign objects. For each of these categories of events, this report will discuss what we have learned about why these events happen, what's being done to prevent them from happening again, and how we can continue to move down the path towards having the safest possible healthcare system.

Frequency of events

Between October 7, 2009, and October 6, 2010, a total of 305 adverse health events were reported to MDH, a slight increase from the 301 events in the previous reporting cycle.

FIGURE 2: AVERAGE MONTHLY EVENTS BY QUARTER



**Note: Q1 figure includes some events that were included in the January 2010 annual report. Events that occurred prior to 10/1/09 but were discovered during the current reporting period are not included in this chart.*

Overall, the data show that:

- The monthly average number of events declined from 30 events per month in the first quarter of the year to 21 in the last quarter of the year. Much of this decline was driven by a reduction over the year in pressure ulcers, which dropped from 14 per month in the first quarter to eight per month in the fourth quarter. Retained foreign objects also declined over the year, falling from more than four events per month in the first quarter to two events per month in the fourth quarter (Figure 2). Other event categories stayed roughly constant across the year.
- 60 hospitals and two ambulatory surgical centers reported events during this reporting period.
- Since the inception of the reporting system, 97 hospitals have reported at least one event. This represents more than 70 percent of all hospitals, which together account for more than 90 percent of all hospital beds in Minnesota.
- During 2009, the most recent year for which preliminary data are available, Minnesota hospitals reported roughly 2.6 million patient days. Accounting for the volume of care provided across all hospitals in the state shows that roughly 11.4 events were reported by hospitals per 100,000 total patient days.

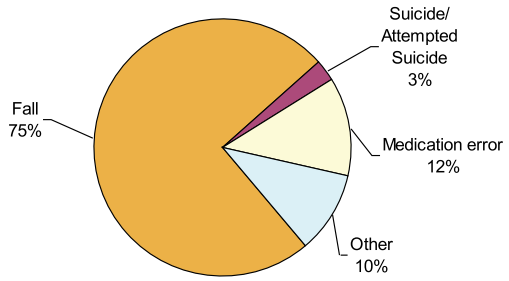
Patient harm

The goal of this reporting system is to prevent any case of unintentional, preventable harm from occurring. The best way to do this is to discover why events happen, develop strong responses to prevent their recurrence, and implement practices that can minimize harm if adverse events do occur. Over time, this process should result in fewer incidents of patient harm over time, along with a reduction in the severity of harm.

On this measure, the current reporting period shows little change from previous years. Overall, serious patient harm was slightly higher in this reporting year than in previous years. A total of 97 events (31.8 percent) resulted in serious disability and ten events (3.3 percent) resulted in a patient's death. The remainder of events resulted in no harm, a need for additional monitoring, or a longer stay. Since the inception of the reporting system, 101 patient deaths have been reported.

As in previous years, the types of events most likely to lead to serious patient harm or death were falls; 75 percent of all cases of serious patient harm or death were related to falls (Figure 3). Medication errors accounted for twelve percent of all cases of serious patient harm or death, while suicide/attempted suicide accounted

FIGURE 3: SERIOUS INJURY/DEATH

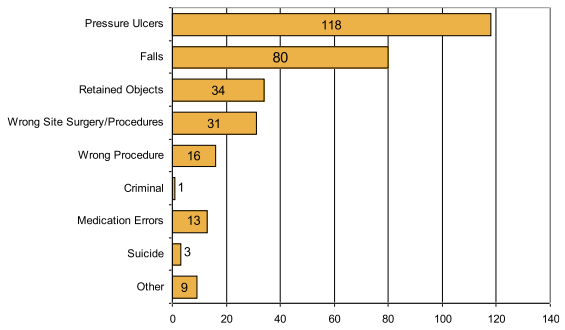


for three percent. Over the life of the reporting system, falls, medication errors, device malfunctions, and suicide/attempted suicide have been the most common causes of serious patient harm.

Types of Events

As in previous years, pressure ulcers and falls were the most commonly reported types of events, accounting for two-thirds of all reported events. Over the seven years in which adverse health events have been reported, pressure ulcers and falls have accounted for roughly 70 percent of all reported events. (Figure 4)

FIGURE 4: EVENTS BY CATEGORY



Root Causes of Adverse Events

When an adverse event occurs, facilities are required to conduct a root cause analysis. This process involves gathering a team to closely examine the system factors that led to the event. These factors can include communication, staffing levels, training, equipment malfunctions, failure to follow policies or protocols, or confusion about roles and responsibilities. The process of completing a root cause analysis is a crucial step in determining exactly what happened and why. The term "root cause" is largely a misnomer; most events have more than one root cause, and several contributing factors.

Without uncovering root causes, it is very difficult to prevent a recurrence of an event. It's important that facilities also look at patterns of events; if multiple similar events occur, analysis of their root causes can reveal patterns of vulnerability that might not be apparent from one event.

On occasion, reporting facilities report cases where the complexity of a patient's clinical condition makes prevention of the event particularly challenging, or even impossible, and no root cause is identified: this is most common with pressure ulcers. However, the vast majority of events can be traced to breakdowns in larger systems of care rather than to individual patient characteristics or individual provider mistakes.

ROOT CAUSES/CONTRIBUTING FACTORS*

Rules/Policies/Procedures	30%
Communication	25%
Environment/Equipment	23%
Training	14%
Barriers	6%
Fatigue/Scheduling	2%

** Does not include events with no identified root cause.*

As in previous years, the majority of adverse events were tied to root causes in one of three areas: communication, policies/procedures, and environment/equipment. However, not all root causes fit neatly into these categories, and in many cases the causes are closely intertwined. For example, even in cases where a policy is in place to prevent something from happening, it may not be correctly implemented due to a lack of understanding of the roles of individuals in carrying out the policy (training), an inadequately written rule (rules/policies/procedures), pressure to complete a process quickly (scheduling), forgetting about a step or a rule at the end of a shift (fatigue), distractions (environment), misunderstandings about what has been done or needs to be done (communication), or physical factors that prevent staff from carrying out the policy (barriers). Issues of organizational culture can also come into play, particularly in cases where providers, staff, or patients feel uncomfortable speaking up if they perceive a risk.

Because the root causes of these events are complex and often system-wide, simple solutions or quick fixes are unlikely to succeed in the long term in preventing their recurrence. In the field of patient safety, interventions that rely on an individual's vigilance or memory are generally considered weaker interventions. Eventually, unless the underlying system or work process is changed, the individual is bound to err, become complacent, or drift from best practice. For improvements to truly become imbedded in a facility, the 'correct' thing to do must also be the easy thing to do. That means that processes should be simplified where possible, strong technical fixes should be put in place to make it impossible to take shortcuts, and workflow and staffing should be organized in such a way that staff are able to make the right choice every time.

GENERATING AND MAINTAINING WILL

JAMES L. REINERTSEN, M.D., THE REINERTSEN GROUP

The Board is ultimately responsible for everything, especially what goes wrong. And despite extensive safety efforts and campaigns, plenty still goes wrong. In November 2010, the Office of the Inspector General reported that 1 in 7 hospitalized Medicare patients experiences largely preventable harm, and 1.5% of those patients die as a direct result.[1] Within the same month, researchers in the New England Journal of Medicine reported a North Carolina rate of 25 harm events per 100 admissions, a rate that has remained essentially unchanged between 2002 and 2007.[2]

We know how to prevent much of this harm. A recent Dutch study showed that 39% of surgical harm, and 50% of surgical deaths, could be prevented by a thorough application of checklists at key points in the surgical journey.[3] This study builds on many others that have shown similar dramatic reductions in infections and other harm events when checklists, safety protocols, and other methods are used reliably.

So if we know how to prevent much of this harm, why don't we? In many instances, it's because hospitals lack the WILL to insist on rigorous application of known safety methods.

How do Boards generate WILL?

- **Stories:** The best Boards start every meeting with a story about a patient's experience, chosen to illustrate the harm data that the Board will review in the meeting. The story is scripted, brief (3 minutes or less), and told without all the medical details. The Chair of a Board working on preventable deaths said, "We are going to tell a story of a recent preventable death at every meeting, until there isn't one to tell."
- **Eliminate the Denominator:** Board safety dashboards tend to show complicated risk-adjusted rates of harm per 1,000 patient or device-days. But the best Boards see the actual number of patients harmed, not just some abstract rate. Some Boards even see the first name of each patient harmed.
- **Go Naked:** The best Boards publicize safety goals and performance. When your community knows that you are aiming to reduce infections, or safety events, or surgical harm, and you regularly send them reports on your progress, it's highly likely that your staff will take the necessary steps to get results. As Tapscott and Ticoll have framed it, "If you're going to go naked, it's good to be buff."

Does your Board have the WILL to expect medical and nursing staff to use known safety practices? If not, you might want to hear stories, eliminate the denominator, and go naked.

[1] *OEI 06-09-0090. Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. November 2010*
[2] *Landrigan CP et al. Temporal Trends in Rates of Patient Harm Resulting from Medical Care. N Eng. J. Med 2010; 363:2124-34*
[3] *De Vries EN et al. Effect of a Comprehensive Surgical Safety System on Patient Outcomes. N Eng J Med 2010; 363:1928-37*

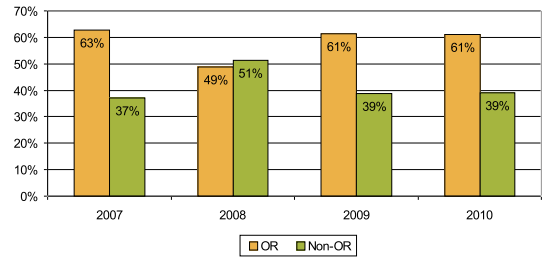
WRONG SITE SURGERY/INVASIVE PROCEDURES

Over the seven years that the adverse events reporting system has been in place, nearly 250 incidents of wrong site, wrong procedure, or wrong patient surgeries and invasive procedures have been reported by Minnesota hospitals and ambulatory surgical centers. In the most recent reporting year, 48 wrong patient, procedure or site events were reported, up from 44 in the previous reporting year. The most common types of reported wrong site or wrong procedure events involved spinal or other orthopedic procedures, regional anesthetic blocks or other injections, and cystoscopies with stent placement/removal.

Across all Minnesota hospitals, more than 2.6 million surgeries and invasive procedures were performed in 2009, with thousands more taking place in ambulatory surgical centers. Given the volume of invasive procedures performed in a year, these events are very rare, occurring in roughly one of every 60,000 invasive procedures.

Of the reported wrong site, patient or procedure cases, more than 60 percent happened in the operating room (including outpatient surgical procedures), with the remainder happening in procedural areas such as radiology or radiation therapy. Of the procedural areas, the interventional radiology unit was the most common location for wrong-site, patient or procedure events, with six wrong surgery/invasive procedure cases occurring in radiology. Over the last two years, OR procedures have generally outnumbered non-OR procedures (Figure 5).

FIGURE 5: SURGICAL/INVASIVE PROCEDURE EVENTS BY LOCATION, 2007–2010



In two-thirds of cases, the patient experienced no harm from the incident or required additional monitoring. Roughly 30 percent of patients required additional treatment, usually in the form of a second procedure, and two patients (four percent) experienced a serious disability.

Key findings

As in previous years, the root causes of wrong procedure, site or patient events are often related to breakdowns in the verification processes that lead up to the procedure. These processes can begin weeks before the event, when the procedure is initially ordered or scheduled by a physician's office, and continue up until the moment the procedure begins or even beyond. Often, the breakdowns occur when independent double-checks of information are not done correctly or are not required by policy, or when team members are distracted during complicated procedures or processes.

Among events reported this year, several common themes emerged:

- In spinal procedures, several incidents occurred because temporary markers or clips placed pre-procedure to identify the spinal level were removed prior to the start of the procedure, resulting in loss of visualization of the correct vertebral level.
- In other cases, while a more permanent site mark was present on the skin, it was not visualized during the time-out process, and no team members questioned its absence.
- In several cases, team members were distracted by multiple interruptions during the time-out, or were not fully cognitively engaged.
- In a few cases that occurred in procedural areas, a policy was still not in place for time-out or for site marking.
- In at least two cases, discrepancies among the various scheduling documents for the surgery were not resolved prior to the beginning of the case.
- Human/cognitive factors are often at play when it comes to surgical events. Distractions, interruptions, and confirmation bias (the tendency to look for, or

to see, only that information that confirms what we already thought was true) can all increase the risk of wrong site surgery. The culture within the OR can also play a role, particularly when junior team members are reluctant to speak up about potential errors or assume that others must have knowledge that they lack. This type of issue contributed to at least one event in 2010, when a surgical team assumed that the physician was at the right location and did not independently confirm.

Next steps

Work to prevent wrong site surgeries/invasive procedures continues to accelerate statewide. Hospitals and ambulatory surgical centers have adopted more rigorous processes for time-outs and site marking, particularly in procedural areas, and a 2010 audit showed great progress in the implementation of this important verification step. Roughly 120 hospitals and ambulatory surgical centers continue to participate in MHA's Safe Site campaign, reporting more than 90 percent compliance with a set of best practices for prevention of these events. In addition, five hospitals are participating in a pilot project to strengthen the surgery scheduling process.

But despite this extensive work and progress on specific issues, these preventable events continue to happen at a consistent rate. Eradicating wrong site surgery/invasive procedures must be a team effort, with all providers having a clear understanding of the weaknesses of the current verification system, the rationale for the strengthened approach, and what their role in the process is. Sometimes, though, not all providers support changing processes when they have not experienced an adverse event. Several facilities have reported receiving 'push back' from some physicians and other providers who may not understand the rationale for the changes they are being asked to make, or experiencing issues around needing to individualize room setups or processes based on the preferences of individual physicians (rather than using a standard approach).

Eliminating these events, nearly all of which are preventable, will require stronger communication and teamwork between all members of the care team, as well as strong leadership expectations for compliance by physicians with their role in all verification processes, both within and outside of the OR. We will not be successful until we are practicing the known best practices across all settings for every patient, every procedure, every time.

In 2011, MDH and MHA will be partnering with the University of Minnesota to conduct statewide train-the-trainer sessions on the pre-procedure time-out and verification process, to provide further support to facilities working to help their surgical teams understand and implement stronger verification processes.

SAFETY IN NUMBERS AND INCREASED KNOWLEDGE

GREATER MINNESOTA INITIATIVE FOR SAFE SURGERY

Gone are the days when surgical practices, whether strictly outpatient, office-based or hospital-based, practice in "silos," so that if a patient safety event or near miss occurs, facilities worry that competitors are going to find out. Instead, increased transparency means that events are shared with each other for the sole purpose of learning and hopefully prevention of a similar incident at another facility, competitor or non-competitor.

This need for transparency and sharing was a driving force in the establishment of the Greater Minnesota Initiative for Safe Surgery, or GMISS. GMISS started in St. Cloud in February 2007 and quickly spread to central and then northern Minnesota. The membership includes over 35 hospitals, ambulatory surgery centers, critical access hospitals, and surgical technology training programs that communicate questions and ideas via email. Once a month for most of the year, up to 20 different facilities get together at face to face meetings where deeper sharing of ideas, frustrations, and challenges takes place. Members feel they have found a safe place to discuss the issues they are struggling with, and to get new ideas to move forward.

The Mission Statement for this initiative is quite simple:

> *To encourage and promote integrated, comprehensive safe patient care in the surgical environment in Greater Minnesota through a transparent, collaborative, multi-system approach. To disseminate consistent information and develop intercollegial, standards-based approaches to safe surgical patient care through shared policies and practices.*

One issue that is often discussed is consistency. Most surgeons throughout the region practice in more than one facility, and have found inconsistency in the "rules and guidelines" for safe care of the surgical patient. For example, some facilities required the surgeon to mark the surgical site, but only on certain cases. Others allowed PAs to mark the site, while others were not requiring the site to be marked at all. The pre-procedure Time Out process was another point of inconsistency; of course it needed to be done, but how? What needed to be stated? Who needed to be involved? Surgeons would report to a facility, then ask "why do we have to do that here? They don't do that at the other hospital!" GMISS members believe that standardization leads to better outcomes for patients, while also simplifying processes for surgeons.

To address these issues, GMISS member facilities are working to bring standardization to the safety practices of Informed Consent, Site Marking, and Time Outs. They also support each other on learning and implementing new mandates from the Centers for Medicare Services. GMISS has also worked on educating patients on their role in safety practices with "Speak Up" flyers and booths at local health fairs.

Minnesota is on the leading edge of defining best practices for surgical safety, but many facilities still feel that their way is best. This means that evolving best practices need to be tested in the field. GMISS members have made a commitment to be there, trying, observing, discussing and improving practices in their combined world of large urban and small rural hospitals, and multispecialty and single specialty ambulatory surgery centers. It's hard work, but as one member said "we're all doing the hard work together."

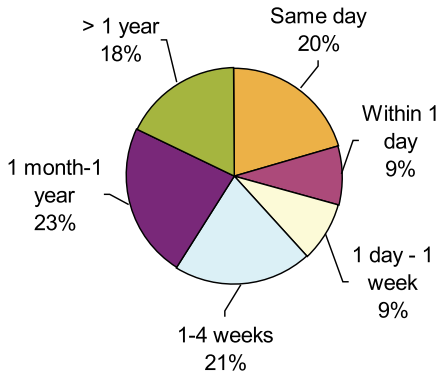
RETAINED FOREIGN OBJECTS

In the most recent reporting year, 34 cases of retained foreign objects were reported. The most commonly retained foreign objects were small sponges or packing or the small tips of instruments that have broken off during a procedure. Nearly half (41 percent) of all retained objects occurred outside of the operating room, in labor and delivery, in procedural areas such as a cardiac catheterization lab or an interventional radiology suite, or during a bedside procedure.

After the 2008 initiation of a Minnesota Hospital Association-sponsored statewide campaign to eliminate retained sponges in labor and delivery, last year's report showed a dramatic drop in these events, from nine in the six months prior to the campaign's kickoff to four in 2009. These improvements have been sustained, with just three retained sponges reported in labor and delivery after vaginal births.

In more than half of all retained object cases, the object retention led to a need for further treatment, usually a second procedure to remove the object. The time that elapsed between the retention of an object and its discovery ranged from a few minutes or hours to more than a year (Figure 6).

FIGURE 6: TIME TO DISCOVERY



Key findings

Whether retained objects occur in the operating room, in labor and delivery, or in a procedural area, the causes are often similar. Most commonly, the system breakdowns that lead to retained objects are of four general types:

- An object was placed by a physician who did not notify other team members of its placement;
- An adequate pre- and post-procedure accounting process did not occur;
- The accounting process did not include a particular type of object; or
- The team was unaware of the risk of breakage of a particular device.

In some cases, these events are due to simple human error – an individual miscounted items, or a provider forgot in this particular instance to tell the team that they were placing a piece of gauze or a sponge. But in many cases, the root causes reveal that there remains wide variation within and across teams in how items are accounted for, whether non-radiopaque items are allowed in the sterile field, whether physicians are aware of and follow current policies and practices around documenting placement of or counting items, and whether team members are empowered to question the placement or removal of items.

Next steps

Recognizing the fallibility of humans conducting repeated counts of objects such as sponges, many hospitals are moving to a focus on 'accounting for' all items before and after procedures. Using this approach, baseline counts of all items are conducted prior to the procedure, and listed on a white board or count sheet. Items are added to this log as they enter the surgical field. Each item is then 'accounted for' at the end of the procedure. Used sponges may be placed into sponge accounting systems or other visual organizers during/after the procedure, with each sponge going into an individual pocket, and other items are checked off on the whiteboard as they are removed. Every item that has entered the surgical field has to be accounted for at the end of the procedure. Some facilities are also using sponges with a barcode or tag that can be detected using a wand, and educating patients on the timeline for removing items that are intentionally retained after a procedure, such as packing.

The MHA "Safe Account" campaign focuses on using this approach to ensure that all items used during a procedure are accounted for, and that facilities use clear and consistent processes for counting. A year into the campaign, the 96 participating hospitals report that they have implemented, on average, 91 percent of the evidence-based best practices for prevention of retained foreign objects. Reports of retained foreign objects declined over the course of this reporting year. Whether that trend is attributable to the Safe Account campaign or other factors is unclear, but work will continue in an attempt to sustain and build on these gains.

PRESSURE ULCERS

Pressure ulcers, otherwise known as bedsores, happen when a patient's skin breaks down due to pressure or friction. The highest-risk patients are those who have limited mobility, circulation problems, or incontinence, although pressure ulcers can also occur in patients with none of these risk factors. The majority of reported pressure ulcers are found on the coccyx or buttocks (40 percent), on the head, neck or face (24 percent), or on the heels, ankles or feet (16 percent). The number of reported pressure ulcers remained constant in the most recent reporting year, dropping just slightly from 122 to 118.

Elderly patients or those who suffer from certain chronic conditions are generally more at risk for the development of pressure ulcers than younger, healthier patients. During this reporting year, the age profile of patients with pressure ulcers decreased somewhat; just over one-third (35 percent) were age 65 or older, while 40 percent were between ages 40 and 64.

Many patients who developed pressure ulcers also had multiple comorbidities or conditions that may have increased their risk for skin breakdown, including respiratory failure, incontinence, malnourishment, diabetes, or kidney or heart failure.

CHARACTERISTICS OF PATIENTS WITH REPORTABLE PRESSURE ULCERS

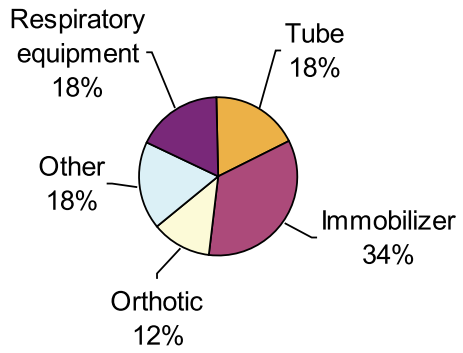
Respiratory failure:	56%
Incontinence:	49%
Clinically malnourished:	48%
Diabetic:	40%
Neurological/neuromuscular condition:	40%
Kidney failure:	33%
Heart failure:	26%

Source: Minnesota Adverse Health Events reporting system, 2010

Key findings

Patient factors, such as morbid obesity or the presence of multiple comorbidities or trauma, can contribute to pressure ulcers by making interventions more complicated or difficult to apply. The use of certain types of devices, such as cervical collars, oxygen masks, or immobilizing boots, can also contribute to the formation of pressure ulcers (Figure 7). Over the course of the year, 30 percent of all reported pressure ulcers were related to the use of devices, most commonly immobilizers such as cervical collars.

FIGURE 7: DEVICES ASSOCIATED WITH PRESSURE ULCERS



Even in these cases, though, the root cause of the pressure ulcer is not the patient's underlying condition alone, but breakdowns in communication about the patient's condition and skin integrity needs, lack of understanding of risk for skin breakdown with device usage, documentation, and awareness and proper implementation of appropriate prevention steps. For example, with certain types of devices that are rarely used, staff may not know the appropriate process for inspecting skin under and around the device, or the appropriate frequency or technique for moving or changing the device. In these cases, additional training for staff and clearer guidelines on when and how to inspect and cleanse skin may be necessary.

During 2010, the Minnesota Hospital Association released recommendations for skin care with the use of cervical collars and respiratory devices. These recommendations include best practices for ensuring proper fit, for device removal and skin inspection, and for skin cleansing.

Next steps

Prevention of pressure ulcers can be a challenging and sometimes frustrating process. Nearly four years after it began, the 92 hospitals that are participating in MHA's Safe Skin campaign report that an average of just over 90 percent of the campaign's bundle of best practices is in place. The campaign will move into a second phase in 2011, with an additional focus on implementing the new device-related pressure ulcer recommendations, improving nutrition assessment and monitoring and preventing pressure ulcers in complex, high-risk patients. In 2010, MHA also launched the "Save our Skin" award, which recognizes facilities that successfully prevent pressure ulcers in complex patients.

PRESSURE ULCER PREVENTION EFFORT ATTACKS CULPRIT HIDDEN IN PLAIN VIEW

FAIRVIEW SOUTHDALE HOSPITAL

Sometimes, the solution to a problem is hidden in plain view. Just ask Vicki Haugen.

The wound, ostomy, and continence nurse (R.N., MPH, CWOCN, OCN) at Fairview Southdale Hospital in Edina works on an effort that began in 2009 to determine why patients were continuing to develop pressure ulcers, or bed sores, during their hospital stay. Prevention methods such as special mattresses that distribute weight more evenly were still not eliminating all occurrences of the painful skin wounds.

Enter data analysis, Haugen said.

"We did a root-cause analysis, and we said, 'Wait a minute — all of these [pressure ulcer victims] were undergoing procedures elsewhere in the hospital.'"

Fully 76 percent of those who developed pressure ulcers in 2008 had undergone three or more procedures such as an X-ray. Sometimes, even a short X-ray can mean a patient is away from his soft, skin-cushioning bed for two hours. Instead, the patient is lying on a firm transport cart mattress or a hard surface that can stress fragile skin.

The trend was eye-opening, Haugen said.

"You just didn't think about that," she said. "There was literally one patient who was gone from his bed for eight hours. So we have this expensive bed, but he wasn't on it."

The study also showed that patients are especially prone to the adverse health events if they are 69 or older and are in the hospital for nine days or more, for instance.

A team then began sharing the news with employees from departments throughout the hospital, including X-ray and administration. They also obtained everyone's prevention ideas.

The cooperation worked.

From October 2009 to October 2010, the hospital's pressure ulcer rate dropped from .35 to .16, per 1,000 patient days.

Today, all departments are required to inspect patients' skin before and after each procedure and document how long the patient was on any pressure areas and what employees did to relieve the weight. Such information is then passed to the next caregiver. Also, transport cart mattresses have been upgraded to a softer version.

Before the hospital's pressure ulcer initiative began, for years it had been implementing other measures to keep skin safe, such as designating participating in the Minnesota Hospital Association's SAFE SKIN program. But none of those efforts had formally addressed prevention related to non-surgical procedures.

The expanded prevention approach is new, and the next edition of the Journal of Wound, Ostomony and Continence Nursing will feature Fairview's initiative. Meanwhile, lessons learned will be shared with Minnesota hospitals.

"With a lot of these kinds of issues, that's why it's so important to do this work as a statewide team," Haugen said. "You don't want to wait for the 'A-ha! moment' to happen somewhere else. You want to share it early."

FALLS

In Minnesota and nationally, falls in the community, in the hospital, or in long term care settings are a leading cause of injury and accidental death. In all of these settings, falls are more likely to happen to the elderly and to those with balance or gait problems, dizziness, or altered elimination/incontinence. Additional risk factors for falls include the use of multiple medications and cognitive impairments.

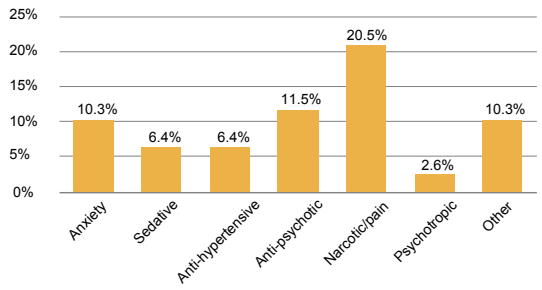
In the previous reporting period, the number of reported falls had declined by 20 percent from 2008. This year, those gains were largely sustained, with the number of reported falls rising just slightly from 76 to 80. The age profile for falls was a bit higher this year; nearly 80 percent involved patients aged 65 or older, and nearly two-thirds percent involved patients 75 or older. Overall, the most common serious injury sustained during a fall was a hip fracture (47 percent), with other lower extremity fractures accounting for an additional 22 percent of injuries. Five patients died of injuries associated with their falls.

Key findings

As in previous years, the most common causes of falls were related to breakdowns in the fall risk assessment process: patients were not appropriately placed at high risk, the risk was not adequately documented or communicated among team members or units, or the risk reduction interventions weren't matched to the patient's individual risk factors or weren't consistently applied. But the falls reported over the last year also revealed other patterns:

- Roughly a third of all falls happened when patients were moving from the bed to the bathroom (either assisted or unassisted), or when they were in the bathroom or using a bedside commode. This suggests that more frequent or more effective offers of toileting assistance, or increased patient education around the need to ask for help with toileting, may be needed.
- Several falls involved patients who were cognitively impaired, or who were not aware of their surroundings at the time of their fall.
- Roughly half of all patients who had a serious fall were on one or more "culprit medications," medications known to increase fall risk, within 24 hours of their fall. Narcotics or other pain medications, anti-psychotic medications, anti-anxiety medications, hypertension medications, and sedatives were the most common culprit medications (Figure 8). Fifteen percent of patients who suffered a serious fall were on multiple culprit medications.
- A number of falls involved patients who had previously always used call lights for assistance, but did not use the light when the fall occurred, possibly due to an improvement in their physical condition or concerns about bothering care team members.
- In nearly 65 percent of falls, a care team member had completed a rounding visit with the patient within 30 minutes prior to the fall to check on pain, position and toileting needs.

FIGURE 9: CULPRIT MEDICATIONS AND FALLS



Next steps

The Minnesota Hospital Association's statewide "Safe from Falls" campaign continued throughout 2010, with more than 100 hospitals participating and reporting that they have implemented more than 90 percent of the campaign's best practices. The campaign is moving into a second phase, with an increased focus on proactive toileting with scripting for nursing staff, keeping patients 'within arm's reach' when offering toileting assistance, reducing high-risk medications, and ensuring that medications are regularly evaluated for all patients who are at risk for falls.

Several hospitals are also piloting a new technique for analyzing serious falls; the 'causal tree' approach allows facilities to explore multiple potential contributing factors using a logic-based approach. Based on the pilot's results, the use of the causal tree methodology may be expanded in 2011, with a template developed for analysis of all serious falls.

UNCOVERING TRENDS AIDS PARK NICOLLET EFFORT TO PREVENT PATIENT FALLS

PARK NICOLLET METHODIST HOSPITAL

Despite a 16-percent reduction in falls from 2008 to 2009, Park Nicollet Methodist Hospital still wasn't satisfied. Digging into the data and getting the bedside nurses involved proved to be the keys to success.

The hospital began a large-scale effort for falls prevention in May 2007, using the Minnesota Hospital Association SAFE from FALLS campaign as a guide. SAFE from FALLS provided structure and methods to attack the potential adverse health events.

The first few years, the data showed that patients known to be high-risk were the ones who fell. But stepped-up efforts to curtail such falls still weren't totally successful.

Further analysis revealed that diagnoses like dizziness and fainting, low blood pressure and confusion were common, said Kristin Roers, R.N., BSN, MS, associate nurse manager and co-leader of Park Nicollet's Falls Prevention Workgroup.

"A nurse at the bedside might think, of course those types of conditions would have an effect on the patient's ability to stand up. But none of today's prevalent medical falls-risk assessment tools would have identified those patients. For us, seeing the trend helped us to realize that diagnosis can play a role, as well as the patient's physical and cognitive abilities."

In reaction, the hospital installed bed and chair alarms that sound if such patients attempt to rise.

Park Nicollet began seeing results in 2009. Further analysis then showed that orthopedic patients who weren't considered at high risk were falling. Victims weren't elderly, those on certain medications or those who had fallen in the past. Instead, they were those who just had joint surgery.

Armed with that information, orthopedic caregivers devised unique prevention solutions for their patients.

The SAFE from FALLS campaign calls for falls-prevention staff "champions." In 2010, the hospital realized that allowing nurses to address the challenge worked best, Roers said.

"It isn't one committee overseeing everything and saying, 'This is how it must be,' " she said. "We have a nurse from each unit involved. We give them time to do one-on-one peer feedback."

The hospital also began storytelling. Every month, articles about a specific patient who fell go beyond statistics to tell about the patient as a person. The vignettes say why the person was in the hospital and what precipitated their accident. The stories then discuss how their fall might have been prevented.

"It has been one of the more effective tools we've used," Roers said. "The storytelling just happened one day, and now it has become part of our culture."

Those and additional techniques ended up helping Park Nicollet reduce its falls 41 percent from 2009 to 2010 (as of late December).

And as a result of implementing SAFE from FALLS, the hospital experienced more than a year without a fall-related reportable adverse health event.

CONCLUSION

The hard work of Minnesota's dedicated healthcare professionals has helped to prevent harm to many patients, and has led to a sustained reduction in falls and a stabilization of the rate of pressure ulcers in Minnesota, along with other improvements. Care teams around the state are thoroughly engaged in preventing these events, and many participate in multiple statewide campaigns to imbed best practices for their prevention. We now know much more about why these events happen than we did in 2003, and are better equipped to develop strong solutions that are being effectively implemented. But despite seven years of hard work and progress in many areas, our overall rate of serious adverse health events remains where it was several years ago.

While human errors can and do occur and can lead to patient harm, we know that adverse health events are far more likely to happen when those human errors combine with breakdowns in communication between care team members across units or facilities, equipment problems, chaotic, busy and distracted environments, unclear policies, lack of compliance with policies, or other systemic issues. The previous seven years have shown us that there is strong support among front-line staff and patient safety leaders to take steps to improve these processes while still holding individuals accountable for their behavioral choices and their competency.

But the dedication of individual care providers, while absolutely necessary, is not enough. Improving patient safety requires a constant focus on preventing harm at all levels of a facility, up to and including CEOs and boards of directors; sufficient resources for implementing all necessary preventive steps; educated, empowered and highly motivated staff; a willingness to make difficult decisions related to resource allocation, physician and staff behavior and compliance with best practices; and the decision to hold all providers accountable for making safety a priority. In order to move to the next level in terms of statewide patient safety and eliminate preventable harm, healthcare leaders – in particular, CEOs, board of directors/trustees, and physicians – need to have the will to keep patient safety as their highest priority in an environment where financial pressures, increased reporting requirements, and a constant flow of new technologies may compete for attention.

There are a number of concrete steps that CEOs and Boards of Directors should take.

Hospital and surgical center CEOs and senior executives should:

- Start every meeting with a story about a patient's experience of preventable harm;
- Regularly observe clinical best practices (such as a pre-surgical time-out) in action;
- Establish, formal, written 'hard stop' policies for critical practices;
- Meet with skin integrity, falls prevention, surgical safety and other teams to learn about challenges and barriers to progress;
- Participate in leadership walk-arounds; and
- Share best practice expectations and performance with the board of directors and with all staff, including licensed independent practitioners.

Boards of directors should:

- Start every meeting with a story about a patient's experience of preventable harm;
- Review safety data that includes actual numbers of patients harmed, not just abstract rates and benchmarks;
- Publicize safety goals and performance; and
- Be required to attend periodic trainings on patient safety issues.

Without these types of committed and ongoing actions, patient safety improvements are likely to plateau, as are reductions in preventable harm.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2009 and October 6, 2010. For each facility, a table shows the number of events reported in each category and the level of severity of each event in terms of patient impact.

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW

Current statutory language is available on the MDH website at **www.health.state.mn.us/patientsafety**

SURGICAL/OTHER INVASIVE PROCEDURE EVENTS

- Surgery/invasive procedure performed on a wrong body part;
- Surgery/invasive procedure performed on the wrong patient;
- The wrong surgical/invasive procedure performed on a patient;
- Foreign objects left in a patient after surgery/ invasive procedure; or
- Death during or immediately after surgery of a normal, healthy patient.

** Note: "Surgery," as defined in the Adverse Health Events Reporting Law, includes endoscopies, regional anesthetic blocks and other invasive procedures.*

ENVIRONMENTAL EVENTS

Patient death or serious disability associated with:

- A fall while being cared for in a facility;
- An electric shock;
- A burn incurred while being cared for in a facility;
- The use of or lack of restraints or bedrails while being cared for in a facility;

And;

- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

PATIENT PROTECTION EVENTS

- An infant discharged to the wrong person;
- Patient death or serious disability associated with patient disappearance; and
- Patient suicide or attempted suicide resulting in serious disability.

CARE MANAGEMENT EVENTS

Patient death or serious disability:

- Associated with a medication error;
- Associated with a reaction due to incompatible blood or blood products;
- Associated with labor or delivery in a low-risk pregnancy;
- Directly related to hypoglycemia (low blood sugar);
- Associated with hyperbilirubinemia (jaundice) in newborns during the first 28 days of life;
- Due to spinal manipulative therapy;

And;

- Stage 3 or 4 pressure ulcers (serious bed sores) or unstageable pressure ulcers acquired after admission to a facility;
- Artificial insemination with the wrong donor sperm or wrong egg.

PRODUCT OR DEVICE EVENTS

Patient death or serious disability associated with:

- The use of contaminated drugs, devices, or biologics;
- The use or malfunction of a device in patient care; and
- An intravascular air embolism (air that is introduced into a vein).

CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
- Abduction of a patient of any age;
- Sexual assault on a patient within or on the grounds of a facility; and
- Death or significant injury of a patient/staff member resulting from a physical assault within or on the grounds of a facility.

TABLE 1: OVERALL STATEWIDE REPORT

Reported adverse health events: **ALL EVENTS** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS							
	SURGICAL	**PRODUCT**	**PATIENT PROTECTION**	**CARE MANAGEMENT**	**ENVIRONMENTAL**	**CRIMINAL**	**TOTAL**
ALL FACILITIES	83 events	3 events	5 events	133 events	80 events	1 event	**305 events**
SEVERITY DETAILS	Serious Disability: 2 Death: 1 Neither: 80	Serious Disability: 2 Death: 1	Serious Disability: 4 Death: 1	Serious Disability: 13 Death: 2 Neither: 118	Serious Disability:75 Death: 5	Serious Disability: 1 Death: 0 Neither: 0	**Serious Disability: 97** **Death: 10** **Neither: 198**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL/INVASIVE PROCEDURE** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS						
	1. WRONG BODY PART	**2. WRONG PATIENT**	**3. WRONG PROCEDURE**	**4. FOREIGN OBJECT**	**5. INTRA/ POST-OP DEATH**	**TOTAL FOR SURGICAL**
ALL FACILITIES	31 events	1 event	16 events	34 events	1 event	**83 events**
SEVERITY DETAILS	Serious Disability: 1 Death: 0 Neither: 30	Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 1 Death: 0 Neither: 15	Serious Disability: 0 Death: 0 Neither: 34	Serious Disability: 0 Death: 1 Neither: 0	**Serious Disability: 2** **Death: 1** **Neither: 80**

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS				
	6. CONTAMINATED DRUGS, DEVICES OR BIOLOGICS	**7. MISUSE OR MALFUNCTION OF DEVICE**	**8. INTRAVASCULAR AIR EMBOLISM**	**TOTAL FOR PRODUCTS OR DEVICES**
ALL FACILITIES	0 Events	0 Events	3 Events	**3 Events**
SEVERITY DETAILS	—	—	Serious Disability: 2 Death: 1	**Serious Disability: 2** **Death: 1**

Details by Category: **PATIENT PROTECTION** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS				
	9. WRONG DISCHARGE OF INFANT	**10. PATIENT DISAPPEARANCE**	**11. SUICIDE OR ATTEMPTED SUICIDE**	**TOTAL FOR PATIENT PROTECTION**
ALL FACILITIES	0 Events	2 Events	3 Events	**5 Events**
SEVERITY DETAILS	—	Serious Disability: 2 Death: 0	Serious Disability: 2 Death: 1	**Serious Disability: 4** **Death: 1**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS	12. DEATH OR DISABILITY DUE TO MEDICATION ERROR	13. DEATH OR DISABILITY DUE TO HEMOLYTIC REACTION	14. DEATH OR DISABILITY DURING LOW-RISK PREGNANCY LABOR OR DELIVERY	15. DEATH OR DISABILITY ASSOCIATED WITH HYPOGLYCEMIA	16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPERBILIRUBINEMIA	17. STAGE 3, 4 OR UNSTAGEABLE PRESSURE ULCERS ACQUIRED AFTER ADMISSION	18. DEATH OR DISABILITY DUE TO SPINAL MANIPULATION	19. ARTIFICIAL INSEMINATION WITH WRONG DONOR EGG OR SPERM	TOTAL FOR CARE MANAGEMENT
ALL FACILITIES	13 Events	0 Events	0 Events	2 Events	0 Events	118 Events	0 Events	0 Events	**133 Events**
SEVERITY DETAILS	Serious Disability: 11 Death: 2	—	—	Serious Disability: 2 Death: 0	—	Serious Disability: 0 Death: 0 Neither: 118	—	—	**Serious Disability: 13** **Death: 2** **Neither: 118**

Details by Category: **ENVIRONMENTAL** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS	20. DEATH OR DISABILITY ASSOCIATED WITH AN ELECTRIC SHOCK	21. WRONG GAS OR CONTAMINATION IN PATIENT GAS LINE	22. DEATH OR DISABILITY ASSOCIATED WITH A BURN	23. DEATH OR SERIOUS DISABILITY ASSOCIATED WITH A FALL	24. DEATH OR DISABILITY ASSOCIATED WITH RESTRAINTS	TOTAL FOR ENVIRONMENTAL
ALL FACILITIES	0 Events	0 Events	0 Events	80 Events	0 Events	**80 Events**
SEVERITY DETAILS	—	—	—	Serious Disability: 75 Death: 5	—	**Serious Disability: 75** **Death: 5**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL EVENTS** (October 7, 2009 – October 6, 2010)

TYPES OF EVENTS					
	25. CARE ORDERED BY SOMEONE IMPERSONATING A PHYSICIAN, NURSE OR OTHER PROVIDER	**26. ABDUCTION OF PATIENT**	**27. SEXUAL ASSAULT OF A PATIENT**	**28. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT**	**TOTAL FOR CRIMINAL EVENTS**
ALL FACILITIES	0 Events	0 Events	0 Events	1 Event	**1 Event**
SEVERITY DETAILS	—	—	—	Serious Disability: 1 Death: 0 Neither: 0	**Serious Disability: 1** **Death: 0** **Neither: 0**

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address:
800 E. 28th St.
Minneapolis, MN 55407-3723

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
952

Number of surgeries/invasive procedures performed:
137,323

Number of patient days:
244,074

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**5**	Deaths: 0;	Serious Disability: 0;	Neither: 5
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**5**	Deaths: 0;	Serious Disability: 5;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**12**	**Deaths: 0;**	**Serious Disability: 5;**	**Neither: 7**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

AUSTIN MEDICAL CENTER – MAYO HEALTH SYSTEM

Address:
1000 First Drive N.W.
Austin, MN 55912-2941

Website:
www.austinmedicalcenter.org

Phone number:
507-434-1706

Number of beds:
82

Number of surgeries/invasive procedures performed:
15,024

Number of patient days:
41,116

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

BETHESDA HOSPITAL

Address:
559 Capitol Blvd.
St. Paul, MN 55103-2101

Website:
www.healtheast.org/patientsafety

Phone number:
651-326-3790

Number of beds:
254

Number of surgeries/invasive procedures performed:
551

Number of patient days:
40,149

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

BIGFORK VALLEY HOSPITAL

Address:
258 Pine Tree Dr.
Bigfork, MN 56628

Website:
www.bigforkvalley.org

Phone number:
218-743-4249

Number of beds:
20

Number of surgeries/invasive procedures performed:
551

Number of patient days:
3,384

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

CAMBRIDGE MEDICAL CENTER

Address:
701 Dellwood St. S.
Cambridge, MN 55008-1920

Website:
www.cambridgemedicalcenter.com

Phone number:
612-775-9762

Number of beds:
86

Number of surgeries/invasive procedures performed:
15,238

Number of patient days:
40,624

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

CANNON FALLS MEDICAL CENTER – MAYO HEALTH SYSTEM

Address:
1116 W. Mill Street
Cannon Falls, MN 55009-1824

Website:
www.cannonhealth.org

Phone number:
507-263-7657

Number of beds:
21

Number of surgeries/invasive procedures performed:
1,426

Number of patient days:
3,233

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**2**	Deaths: 1; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

CENTRACARE HEALTH SYSTEM – MELROSE

Address:
525 W. Main St.
Melrose, MN 56352-1043

Website:
www.centracare.com

Phone number:
320-256-1805

Number of beds:
28

Number of surgeries/invasive procedures performed:
2,731

Number of patient days:
5,313

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

CHILDREN'S HOSPITALS AND CLINICS – MINNEAPOLIS

Address:
2525 Chicago Ave. S.
Minneapolis, MN 55404-4518

Website:
www.childrensmn.org

Phone number:
612-813-6615

Number of beds:
153

Number of surgeries/invasive procedures performed:
28,573

Number of patient days:
75,055

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

CHILDREN'S HOSPITALS AND CLINICS – MINNETONKA

Address:
6050 Clearwater Drive
Minnetonka, MN 55343-9467

Website:
www.childrensmn.org

Phone number:
612-813-6615

Number of surgeries/invasive procedures performed:
4,753

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

CHIPPEWA COUNTY – MONTEVIDEO HOSPITAL

Address:
824 N. 11th St.
Montevideo, MN 56265-1629

Website:
www.montevideomedical.com

Phone number:
320-321-8100

Number of beds:
30

Number of surgeries/invasive procedures performed:
5,472

Number of patient days:
12,199

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

CLOQUET COMMUNITY MEMORIAL HOSPITAL

Address:
512 Skyline Blvd.
Cloquet, MN 55720-1199

Website:
www.cloquethospital.com

Phone number:
218-878-7051

Number of beds:
36

Number of surgeries/invasive procedures performed:
3,322

Number of patient days:
12,617

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

CUYUNA REGIONAL MEDICAL CENTER

Address:
320 E. Main St.
Crosby, MN 56441-1645

Website:
www.cuyunamed.org

Phone number:
218-546-2300

Number of beds:
42

Number of surgeries/invasive procedures performed:
10,171

Number of patient days:
14,526

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

ESSENTIA HEALTH ST. MARY'S HOSPITAL – DETROIT LAKES

Address:
1027 Washington Ave.
Detroit Lakes, MN 56501-3409

Website:
www.trustedcareforlife.org

Phone number:
218-847-0888

Number of beds:
87

Number of surgeries/invasive procedures performed:
7,454

Number of patient days:
15,218

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

ESSENTIA HEALTH DULUTH

Address:
502 E. Second St.
Duluth, MN 55805-1913

Website:
www.essentiahealth.org

Phone number:
218-786-4154

Number of beds:
165

Number of surgeries/invasive procedures performed:
18,342

Number of patient days:
134,631

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 3; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

ESSENTIA HEALTH FOSSTON

Address:
900 Hilligoss Blvd. S.E.
Fosston, MN 56542-1542

Website:
www.firstcare.org

Phone number:
218-435-7649

Number of beds:
43

Number of surgeries/invasive procedures performed:
2,992

Number of patient days:
5,812

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Disability: 1**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

ESSENTIA HEALTH ST. JOSEPH'S MEDICAL CENTER

Address:
523 N. Third St.
Brainerd, MN 56401-3054

Website:
www.essentiahealth.org

Phone number:
218-828-7641

Number of beds:
162

Number of surgeries/invasive procedures performed:
27,102

Number of patient days:
49,588

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

ESSENTIA HEALTH ST. MARY'S MEDICAL CENTER

Address:
407 E. Third St.
Duluth, MN 55805-1950

Website:
www.essentiahealth.org

Phone number:
218-786-4154

Number of beds:
380

Number of surgeries/invasive procedures performed:
75,181

Number of patient days:
107,560

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 1;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**8**	**Deaths: 1;**	**Serious Disability: 2;**	**Neither: 5**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

FAIRMONT MEDICAL CENTER – MAYO HEALTH SYSTEM

Address:
800 Medical Center Dr.
Fairmont, MN 56031-4575

Website:
www.fairmontmedicalcenter.org

Phone number:
507-238-5101

Number of beds:
57

Number of surgeries/invasive procedures performed:
9,760

Number of patient days:
28,464

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 3**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

FAIRVIEW LAKES HEALTH SERVICES

Address:
5200 Fairview Blvd.
Wyoming, MN 55092-8013

Website:
www.fairview.org

Phone number:
951-982-7835

Number of beds:
61

Number of surgeries/invasive procedures performed:
32,980

Number of patient days:
37,460

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 1;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

FAIRVIEW NORTHLAND MEDICAL CENTER

Address:
911 Northland Drive
Princeton, MN 55371-2172

Website:
www.fairview.org/hospitals/northland

Phone number:
763-389-6481

Number of beds:
54

Number of surgeries/invasive procedures performed:
17,688

Number of patient days:
21,766

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

FAIRVIEW RED WING MEDICAL CENTER

Address:
701 Fairview Blvd.
Red Wing, MN 55066-0095

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
50

Number of surgeries/invasive procedures performed:
12,358

Number of patient days:
26,653

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

FAIRVIEW RIDGES HOSPITAL

Address:
201 E. Nicollet Blvd.
Burnsville, MN 55337-5799

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
150

Number of surgeries/invasive procedures performed:
57,320

Number of patient days:
64,303

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

FAIRVIEW SOUTHDALE HOSPITAL

Address:
6401 France Ave. S.
Edina, MN 55435-2104

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
390

Number of surgeries/invasive procedures performed:
107,801

Number of patient days:
133,996

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**2**	Deaths: 1;	Serious Disability: 1;	Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**5**	Deaths: 0;	Serious Disability: 0;	Neither: 5
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**7**	Deaths: 1;	Serious Disability: 6;	Neither: 0
PATIENT PROTECTION EVENTS				
Patient death or serious disability associated with patient disappearance	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**18**	**Deaths: 2;**	**Serious Disability: 8;**	**Neither: 8**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

FAIRVIEW UNIVERSITY MEDICAL CENTER – MESABI

Address:
750 E. 34th St.
Hibbing, MN 55746-2341

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
175

Number of surgeries/invasive procedures performed:
18,111

Number of patient days:
47,268

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

GLENCOE REGIONAL HEALTH SERVICES

Address:
1805 Hennepin Ave. N.
Glencoe, MN 55336-1416

Website:
www.grhsonline.org

Phone number:
320-864-7752

Number of beds:
49

Number of surgeries/invasive procedures performed:
8,694

Number of patient days:
10,694

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Hypoglycemia	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

HENNEPIN COUNTY MEDICAL CENTER

Address:
701 Park Ave. S.
Minneapolis, MN 55415-1623

Website:
www.hcmc.org

Phone number:
612-873-3337

Number of beds:
894

Number of surgeries/invasive procedures performed:
110,728

Number of patient days:
194,176

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Hypoglycemia	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**22**	Deaths: 0;	Serious Disability: 0;	Neither: 22
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
An intravascular air embolism	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**27**	**Deaths: 0;**	**Serious Disability: 5;**	**Neither: 22**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.27

IMMANUEL ST. JOSEPH'S – MAYO HEALTH SYSTEM

Address:
1025 Marsh St., P.O. Box 8673
Mankato, MN 56002-8673

Website:
www.isj-mhs.org

Phone number:
507-385-2938

Number of beds:
272

Number of surgeries/invasive procedures performed:
35,100

Number of patient days:
61,890

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

LAKE REGION HEALTHCARE

Address:
712 Cascade St. S.
Fergus Falls, MN 53537-0728

Website:
www.lrhc.org

Phone number:
218-736-8190

Number of beds:
108

Number of surgeries/invasive procedures performed:
13,364

Number of patient days:
28,965

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

LAKEVIEW HOSPITAL

Address:
927 Churchill St. W.
Stillwater, MN 55082-6605

Website:
www.lakeview.org

Phone number:
651-430-4503

Number of beds:
97

Number of surgeries/invasive procedures performed:
22,251

Number of patient days:
25,716

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30

LAKEWOOD HEALTH CENTER

Address:
600 Main Ave. S.
Baudette, MN 56623-2855

Website:
www.lakewoodhealthcenter.org

Phone number:
218-634-3417

Number of beds:
15

Number of surgeries/invasive procedures performed:
257

Number of patient days:
2,947

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

LIFECARE MEDICAL CENTER

Address:
715 Delmore Drive
Roseau, MN 56751-1534

Website:
www.lifecaremedicalcenter.org

Phone number:
218-463-2500

Number of beds:
25

Number of surgeries/invasive procedures performed:
2,110

Number of patient days:
12,305

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

MEEKER MEMORIAL HOSPITAL

Address:
612 S. Sibley Ave.
Litchfield, MN 55355-3340

Website:
www.meekermemorial.org

Phone number:
320-693-4509

Number of beds:
38

Number of surgeries/invasive procedures performed:
6,549

Number of patient days:
12,975

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

MERCY HOSPITAL

Address:
4050 Coon Rapids Blvd. N.W.
Coon Rapids, MN 55433-2522

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
271

Number of surgeries/invasive procedures performed:
82,259

Number of patient days:
125,413

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
An intravascular air embolism	**1**	Deaths: 1;	Serious Disability: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 1;**	**Serious Disability: 0;**	**Neither: 3**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

NORTH COUNTRY HEALTH SERVICES

Address:
1300 Anne St. N.W.
Bemidji, MN 56601-5103

Website:
www.nchs.com

Phone number:
218-333-6422

Number of beds:
118

Number of surgeries/invasive procedures performed:
20,939

Number of patient days:
39,273

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 3**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

NORTH MEMORIAL MEDICAL CENTER

Address:
3300 Oakdale Ave. N.
Robbinsdale, MN 55422-2926

Website:
www.northmemorial.com

Phone number:
763-520-5183

Number of beds:
518

Number of surgeries/invasive procedures performed:
97,319

Number of patient days:
149,060

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**8**	**Deaths: 0;**	**Serious Disability: 0;**	**Neither: 8**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

OLMSTED MEDICAL CENTER

Address:
210 Ninth St. S.E.
Rochester, MN 55901-6425

Website:
www.olmmed.org

Phone number:
507-292-7203

Number of beds:
61

Number of surgeries/invasive procedures performed:
25,308

Number of patient days:
30,562

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Death of a normal, healthy patient during or immediately after surgery	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

OWATONNA HOSPITAL

Address:
2250 26th St. N.W.
Owatonna, MN 55060-5503

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
43

Number of surgeries/invasive procedures performed:
13,575

Number of patient days:
18,887

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

PARK NICOLLET METHODIST HOSPITAL

Address:
6500 Excelsior Blvd.
St Louis Park, MN 55426-4702

Website:
www.parknicollet.com

Phone number:
952-993-6057

Number of beds:
426

Number of surgeries/invasive procedures performed:
110,325

Number of patient days:
155,905

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**11**	Deaths: 0;	Serious Disability: 0;	Neither: 11
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**20**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 18**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

PHILLIPS EYE INSTITUTE

Address:
2215 Park Ave.
Minneapolis, MN 55404-3711

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
20

Number of surgeries/invasive procedures performed:
15,684

Number of patient days:
7,283

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

PIPESTONE COUNTY MEDICAL CENTER

Address:
916 Fourth Ave. S.W.
Pipestone, MN 56164-1890

Website:
www.pcmchealth.org

Phone number:
507-825-6163

Number of beds:
25

Number of surgeries/invasive procedures performed:
5,774

Number of patient days:
6,745

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

RAINY LAKE MEDICAL CENTER

Address:
1400 Highway 71
International Falls, MN 56649-2154

Website:
www.rainylakemedical.com

Phone number:
218-283-5427

Number of beds:
49

Number of surgeries/invasive procedures performed:
4,062

Number of patient days:
9,643

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

RC HOSPITAL & CLINICS

Address:
611 E. Fairview
Olivia, MN 56277-4213

Website:
www.rchospital.com

Phone number:
320-523-3447

Number of beds:
25

Number of surgeries/invasive procedures performed:
2,171

Number of patient days:
4,927

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/Other invasive procedure performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.43

REGENCY HOSPITAL OF MINNEAPOLIS

Address:
1300 Hidden Lakes Parkway
Golden Valley, MN 55422-4286

Website:
www.regencyhospital.com

Phone number:
763-302-8301

Number of beds:
92

Number of surgeries/invasive procedures performed:
N/A

Number of patient days:
16,975

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**3**	Deaths: 1; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 1; Serious Disability: 2; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

REGINA MEDICAL CENTER

Address:
1175 Nininger Road
Hastings, MN 55033-1056

Website:
www.reginamedical.org

Phone number:
651-480-4141

Number of beds:
57

Number of surgeries/invasive procedures performed:
11,801

Number of patient days:
21,145

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS		
Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.45

REGIONS HOSPITAL

Address:
640 Jackson St.
St. Paul, MN 55101-2502

Website:
www.regionshospital.com

Phone number:
651-254-0760

Number of beds:
454

Number of surgeries/invasive procedures performed:
114,077

Number of patient days:
181,006

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**8**	Deaths: 0;	Serious Disability: 0;	Neither: 8
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**4**	Deaths: 0;	Serious Disability: 4;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**15**	**Deaths: 0;**	**Serious Disability: 5;**	**Neither: 10**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.46

RIDGEVIEW MEDICAL CENTER

Address:
500 S. Maple St.
Waconia, MN 55387-1752

Website:
www.ridgeviewmedical.org

Phone number:
952-442-2191

Number of beds:
109

Number of surgeries/invasive procedures performed:
40,033

Number of patient days:
44,086

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.47

RIVERVIEW HEALTH

Address:
323 S. Minnesota St.
Crookston, MN 56716-1601

Website:
www.riverviewhealth.org/links

Phone number:
218-281-9412

Number of beds:
49

Number of surgeries/invasive procedures performed:
6,574

Number of patient days:
11,893

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.48

ROCHESTER METHODIST HOSPITAL

Address:
201 W. Center St.
Rochester, MN 55902-3003

Website:
www.mayoclinic.org/event-reporting

Phone number:
507-284-5005

Number of beds:
794

Number of surgeries/invasive procedures performed:
143,236

Number of patient days:
140,102

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0;	Serious Disability: 0;	Neither: 3
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 8**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.49

SAINT ELIZABETH'S MEDICAL CENTER

Address:
1200 Grant Blvd. W.
Wabasha, MN 55981-1042

Website:
www.ministryhealth.org/semc/home

Phone number:
651-565-5580

Number of beds:
31

Number of surgeries/invasive procedures performed:
2,881

Number of patient days:
4,435

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.50

SAINT MARY'S HOSPITAL

Address:
1216 Second St. S.W.
Rochester, MN 55902-1906

Website:
www.mayoclinic.org/event-reporting

Phone number:
507-284-5005

Number of beds:
1,157

Number of surgeries/invasive procedures performed:
132,805

Number of patient days:
249,787

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**3**	Deaths: 0;	Serious Disability: 0;	Neither: 3
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**20**	Deaths: 0;	Serious Disability: 0;	Neither: 20
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**5**	Deaths: 1;	Serious Disability: 4;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**33**	**Deaths: 1;**	**Serious Disability: 5;**	**Neither: 27**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.51

SANFORD MEDICAL CENTER THIEF RIVER FALLS

Address:
P.O. Box 531
Thief River Falls, MN 56701-0531

Website:
www.sanfordhealth.org

Phone number:
218-683-4405

Number of beds:
99

Number of surgeries/invasive procedures performed:
4,296

Number of patient days:
14,581

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.52

ST. CLOUD HOSPITAL

Address:
1406 Sixth Ave N.
St. Cloud, MN 56503-1900

Website:
www.centracare.com

Phone number:
320-229-4983

Number of beds:
489

Number of surgeries/invasive procedures performed:
100,654

Number of patient days:
176,029

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
A medication error	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**5**	Deaths: 0; Serious Disability: 5; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 0; Serious Disability: 7; Neither: 3**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.53

ST. CLOUD SURGICAL CENTER

Address:
1526 Northway Drive
St. Cloud, MN 56303

Website:
www.stcsurgicalcenter.com

Phone number:
320-251-8385

Number of surgeries/invasive procedures performed:
11,255

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.54

ST. FRANCIS REGIONAL MEDICAL CENTER

Address:
1455 St. Francis Ave.
Shakopee, MN 55379-3380

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
93

Number of surgeries/invasive procedures performed:
29,486

Number of patient days:
38,710

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 2; Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.55

ST. JOHN'S HOSPITAL

Address:
1575 Beam Ave.
Maplewood, MN 55109-1126

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-7122

Number of beds:
184

Number of surgeries/invasive procedures performed:
69,935

Number of patient days:
83,556

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability:1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.56

ST. JOSEPH'S HOSPITAL

Address:
45 W. 10th St.
St. Paul, MN 55102-1062

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-5613

Number of beds:
401

Number of surgeries/invasive procedures performed:
38,230

Number of patient days:
91,144

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither:1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.57

ST. LUKE'S HOSPITAL

Address:
915 E. First St.
Duluth, MN 55805-2107

Website:
www.slhduluth.com

Phone number:
218-249-5389

Number of beds:
267

Number of surgeries/invasive procedures performed:
48,717

Number of patient days:
82,845

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.58

UNITED HOSPITAL

Address:
333 N. Smith Ave.
St. Paul, MN 55102-2344

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
546

Number of surgeries/invasive procedures performed:
88,612

Number of patient days:
154,375

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1;	Serious Disability: 0;	Neither: 0
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
An intravascular air embolism	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1;**	**Serious Disability: 4;**	**Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.59

UNITY HOSPITAL

Address:
550 Osborne Road N.E.
Fridley, MN 55432-2718

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
275

Number of surgeries/invasive procedures performed:
46,163

Number of patient days:
76,253

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 3**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.60

UNIVERSITY OF MINNESOTA MEDICAL CENTER – FAIRVIEW

Address:
2450 Riverside Ave.
Minneapolis, MN 55454-1400

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
1,700

Number of surgeries/invasive procedures performed:
149,411

Number of patient days:
293,632

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**6**	Deaths: 0; Serious Disability: 0; Neither: 6
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical/invasive procedure performed	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
PATIENT PROTECTION EVENTS		
Patient death or serious disability associated with patient disappearance	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**17**	Deaths: 0; Serious Disability: 0; Neither: 17
A medication error	**4**	Deaths: 1; Serious Disability: 3; Neither: 0
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**5**	Deaths: 0; Serious Disability: 5; Neither: 0
CRIMINAL EVENTS		
Death or significant injury of patient or staff from physical assault	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**40**	**Deaths: 1; Serious Disability: 10; Neither: 29**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.61

WHEATON COMMUNITY HOSPITAL

Address:
401 12th St. N.
Wheaton, MN 56296-1070

Website:
www.wheatonhealthcare.org

Phone number:
320-563-8226

Number of beds:
25

Number of surgeries/invasive procedures performed:
1,622

Number of patient days:
2,443

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 0**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.62

WOODWINDS HEALTH CAMPUS

Address:
1925 Woodwinds Drive
Woodbury, MN 55125-2270

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-6880

Number of beds:
86

Number of surgeries/invasive procedures performed:
30,089

Number of patient days:
37,827

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2009-OCTOBER 6, 2010)

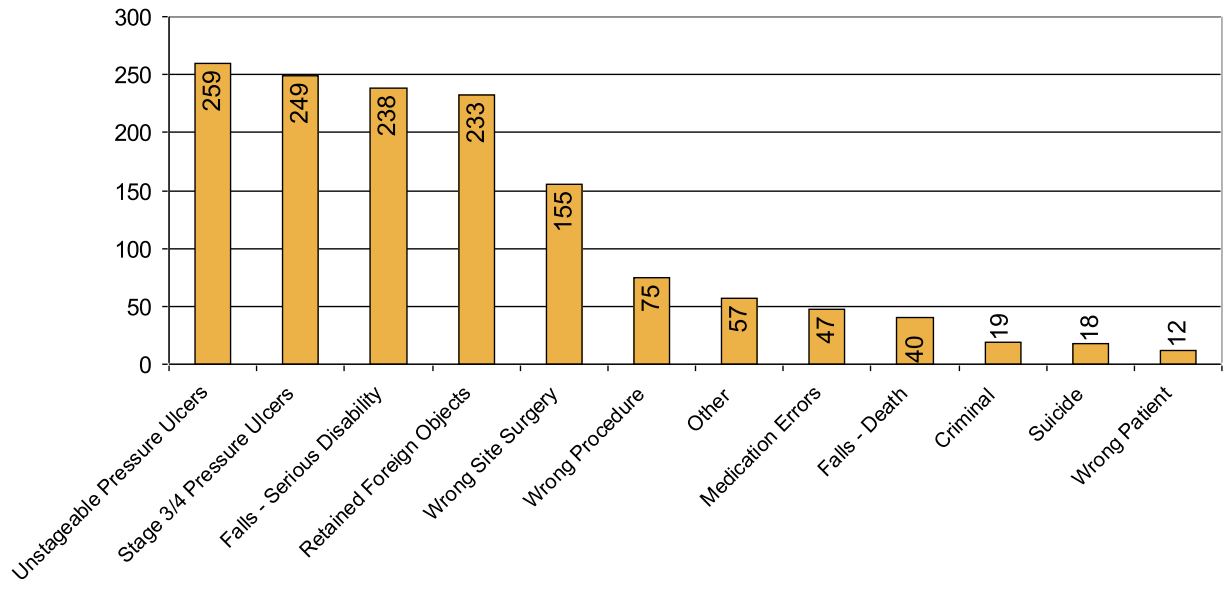
CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 2**

* The surgical/invasive procedure count on this page includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

APPENDIX A:
ADVERSE EVENTS DATA, 2003-2010

Hospitals began reporting adverse health events data to the Minnesota Department of Health in 2003, with ambulatory surgical centers joining the list of required reporting facilities in December, 2004. Since that time, a total of 1,402 events have been reported to MDH.

REPORTED ADVERSE EVENTS, 2003–2010



APPENDIX B:
BACKGROUND ON MINNESOTA'S ADVERSE HEALTH EVENTS REPORTING LAW

In 2003, Minnesota became the first state in the nation to establish a mandatory adverse health event reporting system that included all 27 "never events' identified by the National Quality Forum and a public report that identified adverse events by facility. The law covers Minnesota hospitals, freestanding outpatient surgical centers, and community behavioral health hospitals.

Momentum toward a system for mandatory adverse event reporting began with the publication of the Institute of Medicine report "To Err is Human" in 2000. While the issue of medical errors was not a new one for health professionals, most Americans reacted strongly to the idea that preventable errors could contribute to the deaths of up to 98,000 people per year. The public and media attention that followed the report's publication helped to start a national conversation about the reasons why such errors occur, and a primary focus of the discussions was the concept of systemic causes for errors.

In the past, discussions of medical errors often focused on identifying and punishing those who had caused the error. While individual accountability for behavior that could put patients at risk is very important, the IOM report confirmed that most errors were not the result of the isolated actions of any one care provider, but rather of a failure of the complex systems and processes in health care. Given that knowledge, the old 'blame and train' mentality, wherein individual providers were blamed for mistakes and provided with training in the hopes of preventing future slip-ups, has to make way for a new approach that encompasses a broader view of accountability and learning from errors or near misses.

Every facility has processes for dealing with individual providers who exhibit dangerous or inappropriate behavior or who knowingly put patients at risk. Disciplining, educating or dismissing an individual provider will always be an option in those cases. But the focus of the reporting system is on using focused analysis of events to develop broader opportunities for education about patient safety and best practices – solutions that can be applied across facilities. Responses focused on an individual provider may or may not prevent that provider from making a mistake again, but changing an entire system or process to eliminate opportunities for error, whether by building in cross-checks, establishing a 'stop the line' policy, or using automation to prevent risky choices, will help to keep all patients safer.

From the beginning, the reporting system has been a collaborative effort. Health care leaders, hospitals, doctors, professional boards, patient advocacy groups, health plans, the Minnesota Department of Health, and other stakeholders worked together to create the Adverse Health Care Event Reporting Act, with a shared goal of improving patient safety. The vision for the reporting system is of a tool for quality improvement and education that provides a forum for sharing best practices, rather than a tool for regulatory enforcement.

In 2007, the Adverse Health Care Events Reporting Law was modified to include a 28th event and to expand the definitions of certain other events. The most significant change was an expansion of reportable falls to include those associated with a serious disability in addition to those associated with a death.

APPENDIX C:
REPORTABLE EVENTS AS DEFINED IN THE LAW

Below are the events that must be reported under the law. This language is taken directly from Minnesota Statutes 144.7065. Current statutory language is available on the MDH website at **www.health.state.mn.us/patientsafety**.

Surgical Events[2]

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

2. Surgery performed on the wrong patient;

3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

1. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

2. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

1. An infant discharged to the wrong person;

2. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and

3. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

1 Minnesota Statutes 144.7063, subd. 5 defines 'surgery' as "the treatment of disease, injury, or deformity by manual or operative methods. Surgery includes endoscopies and other invasive procedures."

Care Management Events

1. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
2. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
3. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
4. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
5. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;
6. Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission (includes unstageable ulcers);
7. Patient death or serious disability due to spinal manipulative therapy; and.
8. Artificial insemination with the wrong donor sperm or wrong egg.

Environmental Events

1. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
3. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
4. Patient death or serious disability associated with a fall while being cared for in a facility; and
5. Patient death or serious disability associated with the use of or lack of restraints or bedrails while being cared for in a facility.

Criminal Events

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
2. Abduction of a patient of any age;
3. Sexual assault on a patient within or on the grounds of a facility; and
4. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

APPENDIX D:
SAFETY ALERT – SITE MARKING

Minnesota Hospital Association

MINNESOTA MDH DEPARTMENT of HEALTH

Patient Safety Registry

Minnesota Patient Safety Alert

April 22, 2010

Site marking not located prior to procedure start

Background

The Minnesota Hospital Association (MHA) and the Minnesota Department of Health (MDH) have reviewed data from the adverse health event reporting system and have noted that in 38 percent of wrong site procedures reported since October 2009, the correct site was marked by the person performing the procedure, however, the site mark was not located, and its location shared with the procedure team, as part of the time-out process. Root cause analyses reviewed indicate that in most cases the site mark was not visible after prepping and draping and the team proceeded with the procedure without looking for and locating the site mark.

Recommendation

Marking the site of a surgical or invasive procedure prior to initiation of the procedure is a crucial step in the verification process. However, if that site mark is not visualized during the time-out process, the value of this step is undermined and the final opportunity to prevent a wrong-site or wrong procedure incident may be missed. The community standard for time-out in Minnesota includes visualization and verbal confirmation of the site mark by a member of the operative team as part of a robust, active time-out process.

MHA and MDH recommend that facilities revisit their surgical and other invasive procedure policies and processes to clarify responsibilities for locating the site marking prior to procedure start as part of the time-out process. It is also recommended that observational audits be performed to observe whether or not this step of the process is being completed on a consistent basis.

The Minnesota time-out recommendations include the following steps:

- **Surgeon:** Initiates the time-out
- **Circulator:** Reads aloud the patient's name, 2nd identifier, procedure and procedure site from the informed consent document that has been previously verified during pre-op and asks the team to verify.
- **Anesthesia Care Provider:** States patient's name, 2nd patient identifier and procedure (can be short-hand version of the procedure) with laterality if appropriate.
- **Scrub Person:** 1st – Verifies which procedure they have prepped — can be a shorthand version of the procedure; ***2nd – Visualizes the mark, verbally indicating that he/she sees the mark and where it is located.***
- **Surgeon:** States full procedure; asks scrub person to remove the time-out towel to begin the procedure.

For more information on this alert, contact Julie Apold, MHA director of patient safety, at japold@mnhospitals.org or (651) 641-1121 or toll-free at (800) 462-5393 or Diane Rydrych, assistant director, division of health policy, Minnesota Department of Health, (651) 201-3564.

APPENDIX E:
SAFETY ALERT: ANESTHESIA PROCEDURES

Minnesota Patient Safety Alert

April 22, 2010

Anesthesia procedure preceding surgical procedure

Background

The Minnesota Hospital Association (MHA) and the Minnesota Department of Health (MDH) have reviewed data from the adverse health event reporting system and have noted a cluster of reported events in which anesthesia procedures (e.g. regional block, injections) completed just prior to a related surgical procedure were completed at the incorrect site. Root cause analyses indicate that in most cases the anesthesia procedure and surgical procedure were not treated as separate invasive procedures with site marking and a time-out performed for each procedure. In most cases, the surgical procedure site was marked and a time-out was completed but the anesthesia procedure site was not marked and a time-out was not conducted prior to that procedure.

Recommendation

MHA and MDH recommend that facilities revisit their surgical policies and processes to clarify that anesthesia procedures, such as regional blocks and injections, conducted just prior to a related surgical procedure, should be site marked according to site marking recommendations for anesthesia {link to anesthesia document on safe site toolkit} and a time-out conducted by the procedure team. A second, separate site marking should be completed by the person performing the surgical procedure and a time-out for the surgical procedure conducted by the surgical team just prior to incision or start of the surgical procedure.

For more information on this alert, contact Julie Apold, MHA director of patient safety, at japold@mnhospitals.org or (651) 641-1121 or toll-free at (800) 462-5393 or Diane Rydrych, Assistant Director, Division of Health Policy, MN Department of Health, 651-201-3564.

APPENDIX F:
SAFETY ALERT: CEO ROLE

Minnesota Hospital Association

MINNESOTA MDH DEPARTMENT of HEALTH

Patient Safety Registry

Minnesota Patient Safety Alert

June 22, 2010

Accountability for Safe Site Key Principles – Senior Leadership Action Needed

Background

Although Minnesota hospitals have been working diligently to eliminate wrong patient, wrong site and wrong procedure adverse events and have experienced success in specific areas, we are on target to experience higher numbers of wrong site procedures than ever before.

Examples of wrong site events:

a) Provider continues to have patients mark their own procedure site; wrong site surgery occurs.
b) Team does not see the mark, assumes site mark has been removed with surgical prep, does not stop the procedure to verify.
c) The patient is asked to confirm the operative leg; correct site is not verified with schedule or consent.
d) A time-out is not conducted for an interventional radiology procedure; procedure is performed on the wrong site.

Key issues:

1) The procedure site mark is not consistently being visualized immediately prior to the procedure start resulting in the procedure being conducted in the wrong location.
   In 38% of wrong site cases this year, the procedure site was correctly marked but no one on the team looked for the mark before the start of the procedure.

2) The anesthesia procedure, such as a block, being conducted prior to a surgical procedure is not consistently being treated as a separate invasive procedure with separate site marking and a time-out conducted, resulting in the anesthesia procedure being administered at the incorrect site.
   In 30% of reported cases so far this year, an anesthesia procedure, e.g. block administered prior to a surgical procedure, was completed on the incorrect side/site.

3) Site marking is not being consistently completed for interventional radiology procedures (interventional radiology procedures in which the procedure site is predetermined need to be site marked) resulting in procedures being performed at the incorrect site.
   20% of wrong site procedures last year occurred in interventional radiology.

4) There are not clear expectations communicated that all surgeons and other providers performing procedures follow the Minnesota site marking and time-out recommendations.
   78% of wrong site events this current year had one or more of the key site marking or time-out best practices not completed.

Call-to-Action for Senior Leadership

Key Best Practices — Visualizing Site Mark During Time-Out

This is a step in the time-out process that should be clearly assigned (recommend scrub staff for OR).

If this step is not completed, providers and staff should know that it is an expectation that they speak up to "stop the line" until the mark has been visualized and communicated to the team.

Executive Leadership Actions:

Partner with the Safe Site Surgeon and Operational Champion in your facility to:

- Meet with the OR and procedure teams to discuss barriers and solutions.
- Ask OR and procedure staff in areas such as interventional radiology and anesthesia to share observational audit data with you which includes the percent of time that the site mark was visualized prior to procedure start.
- Observe site marking and time-outs in action. *To see the recommended time-out process in action, go to: http://www.mha-apps.com/media/to.html*

Key Best Practices — Anesthesia Procedures Preceding Surgical Procedure

Anesthesia procedures, such as blocks and injections, should be treated as separate invasive procedures. Site marking by the person performing the procedure, and a time-out by the procedure team, need to be completed for the anesthesia procedure. A second, separate site mark and time-out need to be conducted for the surgical procedure.

Executive Leadership Actions:

- Meet with anesthesia team to discuss barriers and solutions.
- Ask anesthesia staff to share observational audit data with you which includes the percent of time the anesthesia procedure site was marked and a time-out conducted.
- Observe anesthesia procedure site marking and time-outs in action.

Key Best Practices — Interventional Radiology

All interventional radiology procedures in which the procedure site is pre-determined need to be site marked. Reports from radiologists estimate that approximately 95% of interventional radiology procedures are pre-determined (i.e., the procedure and laterality/location of the procedure to be performed are known).

A time-out needs to be conducted by the IR team prior to interventional radiology procedures regardless of whether or not site marking is needed.

Executive Leadership Actions:

- Meet with interventional radiology teams to discuss barriers and solutions.
- Ask interventional radiology staff to share observational audit data with you which includes the percent of time the procedure site was marked, when the site was pre-determined, and a time-out conducted.
- Ask interventional radiology staff to demonstrate their site marking and time-out process to you.
- Observe interventional radiology site marking and time-outs in action.

Key Best Practices — Following Minnesota Time-out and Site Marking Recommendations

The procedure site is marked by the practitioner who is ultimately accountable for the procedure; patients should not sign the site.

All key steps of the time-out are completed by the procedure team for any invasive procedure.

Executive Leadership Actions:

- Establish a formal, written "Hard Stop" (nothing moves forward) policy outlining:

  If these Safe Site actions are not followed, in any area of the hospital (e.g. OR, anesthesia, interventional radiology) staff and physicians should:
  - Be expected to call a "Hard Stop" (nothing moves forward) until these practices are completed;
  - Know that they will be supported in stopping the line;
  - Have a clear channel of communication to follow if they are not supported in their immediate environment in calling for the "Hard Stop";
  - Know the organization's expectations and consequences for not practicing these key Safe Site actions.
- Share the Safe Site actions with your board, along with your hospital's audit data related to site marking and the time-out process in the operating room and areas outside the operating room.

For more information on this alert, contact Tania Daniels, MHA vice president of patient safety, tdaniels@mnhospitals.org or Julie Apold, MHA director of patient safety, japold@mnhospitals.org or by telephone at (651) 641-1121 or toll-free at (800) 462-5393.

ADVERSE HEALTH EVENTS IN MINNESOTA

SEVENTH ANNUAL PUBLIC REPORT

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WWW.HEALTH.STATE.MN.US

MINNESOTA MDH DEPARTMENT OF HEALTH